General Dental Council

# Education Quality Assurance Inspection Report

| Education Provider/Awarding Body | Programme/Award |
|---|---|
| Glasgow Caledonian University | BSc Oral Health Science (Hygiene and Therapy) |

| Outcome of Inspection | Recommended that the qualification continues to be approved for the graduating cohort to register as a Dental Hygienist & Therapist. |
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*Full details of the inspection process can be found in Annex 1*

## Inspection summary

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| **Remit and purpose of inspection:** | **Inspection referencing the *Standards for Education* to determine sufficiency of the award for the purpose of registration with the GDC as a Dental Therapist and Hygienist.**<br><br>**Risk based: focused on requirements 3, 4, 7, 9, 15, and 16.** |
| **Learning Outcomes:** | **Preparing for Practice Dental Therapist and Hygienist.** |
| **Programme inspection dates:** | **20th – 21st May 2025.** |
| **Inspection team:** | **Amanda Orchard (Chair and non-registrant member)**<br>**Linda Gunn (DCP member)**<br>**Joanne Beveridge (DCP Member)**<br>**James Pennington (Education and Quality Assurance Officer)**<br>**James Marshall (Education and Quality Assurance Manager)** |
| **Report Produced by:** | **James Pennington (Education and Quality Assurance Officer)** |

This inspection was a result of the 2024-25 monitoring exercise of the programme, where the following concerns were identified. Staffing levels and the impact this could have on student experience. Awareness that there was a programme re-approval process being conducted by the wider Glasgow Caledonian University. Management of patient safety issues, and finally concerns over quality management of the programme.

This is a three-year programme where students are given practical experience in year one. First year students are able to go to outreach placements and observe to obtain valuable experience before they begin any of the procedures themselves. The outreach opportunities available to students are a particular strength of the programme, students gain an extensive breadth of patient experience, together with the dedication of staff to ensure patients and placements are assigned effectively gives students enormous experience in preparing them for practice. This experience paired with the current small cohorts mean students get extensive experience as well as close support and supervision from staff within Glasgow Dental Hospital (GDH) as well as on outreach placements. The students were very positive about the experience they gain, and about the positive support offered by the staff.

The inspection was conducted on-site over 1.5 days and during this time the staff at the school were incredibly open, honest and forthcoming with any information we requested. This was extremely helpful alongside the comprehensive documentation and evidence provided to the panel prior to the inspection. The panel identified multiple areas of good practice which will be noted during the report. The panel would also like to commend the

staff involved in the programme for their commitment and passion towards the programme and the students. After speaking with both staff and students, it is clear that students are proud to be a student at GCU and staff are equally proud to be a part of the programme. The programme was re-approved by the University and received 5 commendations.

The panel have concluded that requirements 3, 4, 7, 15, and 16 were all ‘’Met’’ and requirement 9 is ‘’Partly Met’’. However, we would like to note the staffs frank acknowledgement of issues relating to requirement 9 and their desire to establish more effective measures to ensure this requirement is met in the future.

The GDC wishes to thank the staff, students, and external stakeholders involved with the BSc Oral Health Science programme for their co-operation and assistance with the inspection.

## Background and overview of qualification

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| Annual intake | 14 students |
| Programme duration | 3 academic years |
| Format of programme | Year 1: 5 Modules undertaken both clinical & theory. Pre-clinical skills simulation, shadowing of Year 2 & 3 students. Proceed to seeing patients in Trimester 2.<br>Year 2: 6 Modules undertaken including Radiography with BDS. Pre- Clinical skills in both Adult restorative and Paediatric dentistry. Continue Perio treatment in GDH and attend Adult Outreach.<br>Year 3: 5 modules undertaken. One day per week in GDH and rotation around all outreach centres adult and paediatric. |
| Number of providers delivering the programme | 1, Glasgow Caledonian University |

## Outcome of relevant Requirements[1]

| Standard One | |
|---|---|
| 1 | Met |
| 2 | Met |
| 3 | Met |
| 4 | Met |
| 5 | Met |
| 6 | Met |
| 7 | Met |
| 8 | Met |
| **Standard Two** | |
| 9 | Partly Met |
| 10 | Met |
| 11 | Met |
| 12 | Met |
| **Standard Three** | |
| 13 | Met |
| 14 | Met |
| 15 | Met |
| 16 | Met |
| 17 | Met |
| 18 | Met |
| 19 | Met |
| 20 | Met |
| 21 | Met |

**Standard 1 – Protecting patients**

[1] All Requirements within the *Standards for Education* are applicable for all programmes unless otherwise stated. Specific requirements will be examined through inspection activity and will be identified via risk analysis processes or due to current thematic reviews.

**Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.**

**Requirement 1: Students must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients.** ***(Requirement Met/Partly Met/Not Met)***

**Requirement 2: Providers must have systems in place to inform patients that they may be treated by students and the possible implications of this. Patient agreement to treatment by a student must be obtained and recorded prior to treatment commencing.** ***(Requirement Met/Partly Met/Not Met)***

**Requirement 3: Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care, including equality and diversity, wherever treatment takes place.** ***(Requirement Met)***

All treatment takes place within two NHS Heath Boards, Greater Glasgow & Clyde and Lanarkshire. As all staff within the Programme Team are NHS employees, they must comply with statutory & mandatory training.

The school is able to use the facilities available at the Glasgow Dental Hospital. These facilities are closely monitored by the school as well as by the wider university.

All staff but one work both within the school and at an outreach centre. This provides consistency of supervision and of marking and assessment. New staff are inducted and have a period of shadowing staff on clinics, this includes providing their own marking and assessment on work carried out by students which is then used to calibrate them to the correct level.

Staff at the school are extremely receptive to students requirements in terms of EDI and have good communication with student support and pastoral support available through GCU. The culmination of this is an environment which can be tailored for each student to allow them to thrive and to learn to the best of their ability.

The panel was assured by the information received prior to the inspection, and therefore further assured during the inspection as this was explained further. The panel was also granted a tour of the GDH facilities which were well equipped and were appropriate for students to complete their procedures in.

**Requirement 4: When providing patient care and services, providers must ensure that students are supervised appropriately according to the activity and the student's stage of development.** ***(Requirement Met)***

The school is benefitting from having smaller cohorts and this enables staff to develop close relationships with the students, so they have good knowledge of each student's progression and capabilities. Students' attainment is tracked through Microsoft Excel which all staff have access to so they can monitor progression but also identify areas where students require more experience. Staff meet every two weeks to discuss student progression and highlight any areas for concern, also giving staff opportunity to discuss student attainment and ensure students have appropriate supervision as well as appropriate procedures and patients. Staff also meet each morning before each clinic to discuss the students they will be working with

that day and where their attention may need to be focused. Staff are able to triage the patients before seeing students to enable effective assignment of patients to students. Students must also complete ‘’check-in’’ and ‘’check-out’’ sheets for each patient which must be signed off by a member of staff which identifies what treatment the patient will be receiving that day, and then this is signed again and reconfirmed at the end of the day. Clinical competencies are completed in all three years of the programme, and these can only be completed in the GDH clinic to ensure consistency of assessment. Students and staff adhere to Local Safety Standards for Invasive Procedures (LocSSIPs).

The school has a dedicated member of staff for timetabling. When staff absence occurs, the school are able to react quickly and adapt the timetable to ensure staff coverage across lectures and clinics. This can include moving lectures to online platforms or students undertaking independent learning followed by a tutorial. This system functions to ensure clinic cancelations are kept to a minimum and patients are not disrupted. The GDH also benefits from having Core Trainees available to assist with supervision and teaching, these individuals are properly inducted into the clinic over a week period where they are taught the scope of practice the students work too.

The panel were told that staff to student ratios are never not met. Clinic groups are sometimes split in half to ensure a 1:4 ratio and to ensure students do not lose out on clinical time. The panel would also like to commend the staff on their commitment to the programme. Staff gave up their free time to staff clinics to ensure students gain the required experience. It is clear the staff’s flexibility has been a huge help in recent times with staff shortages.

Staff are encouraged to maintain their CPD and knowledge. There is a dedicated member of staff that staff can speak to if they want to identify areas of learning they would like and this is then facilitated through the school and wider university. The university has stated that this is a particular area that the school does well and will try to replicate across the university.

**Requirement 5: Supervisors must be appropriately qualified and trained. This should include training in equality and diversity legislation relevant for the role. Clinical supervisors must have appropriate general or specialist registration with a UK regulatory body.** ***(Requirement Met/Partly Met/Not Met)***

**Requirement 6: Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parties how concerns should be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so.** ***(Requirement Met/Partly Met/Not Met)***

**Requirement 7: Systems must be in place to identify and record issues that may affect patient safety. Should a patient safety issue arise, appropriate action must be taken by the provider and where necessary the relevant regulatory body should be notified.** ***(Requirement Met)***

Staff assured the panel that patient safety issues are extremely minimal. Patient safety incidents are reported through ‘DATIX’ for both health boards, and major incidents are also written up as a report. Datix reports include a mandatory section which require staff to detail what learning is taken from the incident. These incidents are reported to the Clinical Governance Manager who also covers the BDS programme, helping to identify common themes and combat issues. Major incidents require the clinical director to sign off in order to investigate, and this investigation concludes with an action plan with strict timescales which is fed through the clinical governance group.

The school reported very low numbers of incidents which may be attributed to the level of supervision each student gets due to the size of the cohorts.

Incidents at outreach centres can be recorded in the student's notes so they get back to the school. The programme lead can also be contacted directly by outreach staff to notify of incidents.

The school has effective means of gathering patient and student feedback, and the panel were assured that feedback is discussed and acted upon appropriately. This will be further detailed later in the report.

The panel were assured by the documentation provided to them and the staff members description of process and policy that if patient safety issues were to occur then they would be handled appropriately, and that effective learning would be taken from these.

**Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance. Providers must also ensure that the GDC's Standard for the Dental Team are embedded within student training.** ***(Requirement Met/ Partly Met/Not Met)***

**Standard 2 – Quality evaluation and review of the programme**
**The provider must have in place effective policy and procedures for the monitoring and review of the programme.**

**Requirement 9: The provider must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function.** ***(Partly Met)***

The panel was assured by a comprehensive quality assurance framework explained in detail by the staff involved. The process uses external stakeholders in a university liaison group. There is a strategic board and a programme board which meet regularly throughout the year and the university uses an annual monitoring exercise each year. The school contributes to a directorate risk register which is updated quarterly and is reported to the regional clinical governance group. Responsibility for the register sits with the Manager of the Oral Health directorate. Staff are encouraged to go to the local operational governance manager to raise items to be added to the register.

This year the programme successfully went through University re-approval, as it must do every 5 years. The programme was re-approved by the university with five commendations; this work was completed alongside the transition work to Safe Practitioner which assisted with ensuring the curriculum was mapped.

Feedback from students and staff is used effectively to monitor the programme and feedback is responded to in a 'you said, we did' format to ensure transparency. This transparency is also mirrored with the External Examiner (EE) reports where the programme lead is required to respond to each report in writing to the examiner to inform them of the status of their feedback.

Previously the GDC had recommended the school implement a 'fit to sit' policy for students who felt they were not fit to sit exams due to extenuating circumstances. The panel found that the current iteration of this policy does not reflect what its purpose was intended to be. Instead, students may be able to take advantage of this policy in order to retain their first attempt at an exam as they can apply for fit to sit exemption up to 48 hours after the exam has been taken. The school did explain that students had been informed about the potential impact applying for fit to sit may have on their journey through the programme. The School recognised and acknowledged this and explained that work had already begun on amending the policy to ensure it was appropriate and could be used for students who have extenuating circumstances which may impact their ability to complete an exam to the best of their ability.

The panel expect that the 'fit to sit' policy be updated to be more appropriate for its intended use. The policy is intended for students who may have extenuating circumstances which prevent them from performing at their best. An update to it would prevent it being taken advantage of, and possibly harming student progression in the future. The policy should also allow for students who staff have clinical concerns about. The policy should allow them to defer the students first attempt and undertake remediation and gain experience to be able to sit the exam at a time where staff feel they are sufficiently prepared.

During the visit we had the opportunity to look through a sample of the physical student portfolios and the digital systems used to track student progress. Staff outlined to the panel that this system current comes with risks, especially with so much being recorded in physical logbooks. This risk could be mitigated by using a more sophisticated, dedicated, online student progression system. The panel expect that in the future the University invest in such a system to mitigate these risks and further improve the way the staff can track student progression.

**Requirement 10: Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes. The provider will have systems in place to quality assure placements.** *(Requirement Met/Partly Met/Not Met)*

**Requirement 11: Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer feedback must be collected and used to inform programme development.** *(Requirement Partly Met)*

**Requirement 12: The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements.** *(Requirement Met/Partly Met/Not Met)*

**Standard 3– Student assessment**
**Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.**

**Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. *(Requirement Met/Partly Met/Not Met)***

**Requirement 14: The provider must have in place management systems to plan, monitor and centrally record the assessment of students, including the monitoring of clinical and/or technical experience, throughout the programme against each of the learning outcomes. *(Requirement Met/Partly Met/Not Met)***

**Requirement 15: Students must have exposure to an appropriate breadth of patients/procedures and should undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant GDC learning outcomes. *(Requirement Met)***

Students have portfolios containing their experience which is then entered onto a central database which staff can access which allows staff and students to see where they may need more experience. Timetables can then be amended to facilitate students as well as their outreach rota being amended to ensure they see a breadth of patients.

Staff triage patients well to assign them appropriately to students. This is also discussed in staff meetings before clinics to ensure the time in clinic is used as best as possible and the students gain appropriate experience.

Outreach placements prepare students for practice giving them real-world experience facilitating a smooth transition into the workplace upon graduation. This is further achieved by staff and supervisors shortening of patient appointments and varying the complexity of procedures, simulating a real-world environment for those students who it is appropriate for at their stage of development.

Integration with BDS students is utilised to simulate the real world and integrate them and the BDS students into the dental team. This also has another advantage in that the BDS students are able to refer patients to the BSc students more appropriately. When speaking to the students, they raised to the panel that because they use different teaching software to the BDS students that they did not have access to the full learning material. Some tutorial videos were cut off midway through and this meant they felt less prepared than the BDS students for these sessions.

**Requirement 16: Providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed. (*Requirement Met)***

This was an area which the university had identified as a particular area of good practice. The school uses their External Examiners (EE) and professional organisations to prepare their exams and assessment and they also use links with other schools delivering similar programmes to share good practice and learning. Each one must be approved by the EEs. We saw examples of EE feedback and the process of approving these amendments. Every exam/assessment also goes through internal scrutiny by at least two members of staff. The school utilises university recourses such as the GCU exams office to ensure the assessments

are written in the correct English format. They also use the academic learning team to assist with exam risks such as AI.

The university was surprised that all assessments are double marked, as this is not required within its policy, however, the school actively chooses to do this as another level of scrutiny and quality assurance. They also use this as an opportunity to train new staff and calibrate them appropriately. The moderation policy is at least 10% for cohorts over 11 students, for cohorts under this all must be moderated. The policy also states that each assessment must have a 70% first diet pass-rate.

The school are currently working on digitising exams upon recommendations from their EE's as this makes them easier to mark. The school uses blended learning technologists to help with designing these online assessments.

**Requirement 17: Assessment must utilise feedback collected from a variety of sources, which should include other members of the dental team, peers, patients and/or customers. (*Requirement Met/Partly Met/Not Met*)**

**Requirement 18: The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice. (*Requirement Met/Partly Met/Not Met*)**

**Requirement 19: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a UK regulatory body. Examiners/ assessors should have received training in equality and diversity relevant for their role. (*Requirement Met/Partly Met/Not Met*)**

**Requirement 20: Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented. (*Requirement Met/Partly Met/Not Met*)**

**Requirement 21: Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments. (*Requirement Met/Partly Met/Not Met*)**

## Summary of Action

| Requirement number | Action | Observations & response from Provider | Due date |
|---|---|---|---|
| 9 | The school must consider that in the future the University invest in an online student progression system. | Meetings scheduled with Senior Stakeholders to explore the possibility of utilising electronic recording systems currently in use by the University of Glasgow for the BDS programme. Consideration must be given to IT interface between two Universities and the financial implication of this. | First meeting 02/09/2025 Updates via GDC's Annual Monitoring. |
| 9 | The school must consider that the Fit to Sit policy requires amending to be more appropriate for its intended use. The policy is intended for students who may have extenuating circumstances which prevent them from performing at their best. The policy should also allow for students who staff have clinical concerns about. The policy should allow them to defer the students first attempt and undertake remediation and gain experience to be able to sit the exam at a time where staff feel they are sufficiently prepared. An update to it would prevent it being taken advantage of and possibly harming student progression in the future. | Previously we have addressed Fit to Sit applications on an individual basis. Whilst we will continue to do this, we have formalised the information given to all students regarding Fit to Sit which will be shared with each cohort during induction week in September 2025. This will ensure an understanding of the possibility of an extension to studies and the impact it may have allowing students to progress from one level of the programme to the next. In addition, Extreme Extenuating Circumstances is another policy which students may use. Dependant on reasons, students may be eligible to apply for a suspension of studies, negating the requirement for Fit to Sit application. We will include information on all policies at Induction sessions for all years in September 2025 emphasising the rational for use of each. We will continue to use Fit to Sit as a way of delivering additional clinical support by way of tailored clinical activity for those who require it, allowing a preserved attempt at exams and preventing students having to withdraw from the programme. | September 2025 with continued monitoring throughout the academic year and via the GDC's Annual Monitoring. |
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## Observations from the provider on content of report

**On behalf of the Programme Team and those involved from the wider strategic group, I would like to sincerely thank the Panel for their comments in this report and for their participation in our Inspection process both during the actual Inspection and in the preparation of it. The Team are encouraged and delighted that their commitment to students and to the University is acknowledged.**

## Recommendations to the GDC

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| **Education associates' recommendation** | The BSc Oral Health Science (Hygiene and Therapy) continues to be approved for holders to apply for registration as a Dental Hygienist and Therapist with the General Dental Council. |
| **Date of next regular monitoring exercise** | October 2026. |

# Annex 1

**Inspection purpose and process**

1. As part of its duty to protect patients and promote high standards within the professions it regulates, the General Dental Council (GDC) quality assures the education and training of student dentists and dental care professionals (DCPs) at institutions whose qualifications enable the holder to apply for registration with the GDC. It also quality assures new qualifications where it is intended that the qualification will lead to registration. The aim of this quality assurance activity is to ensure that institutions produce a new registrant who has demonstrated, on graduation, that they have met the learning outcomes required for registration with the GDC. This ensures that students who obtain a qualification leading to registration are fit to practise at the level of a safe beginner.

2. Inspections are a key element of the GDC's quality assurance activity. They enable a recommendation to be made to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist and 'approval' of the programme for registration as a dental care professional. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended).

3. The GDC document 'Standards for Education' 2nd edition1 is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

4. The education provider is requested to undertake a self-evaluation of the programme against the individual Requirements under the Standards for Education. This involves stating whether each Requirement is 'met', 'partly met' or 'not met' and to provide evidence in support of their evaluation. The inspection panel examines this evidence, may request further documentary evidence and gathers further evidence from discussions with staff and students. The panel will reach a decision on each Requirement, using the following descriptors:

A Requirement is met if:

"There is sufficient appropriate evidence derived from the inspection process. This evidence provides the education associates with broad confidence that the provider demonstrates the Requirement. Information gathered through meetings with staff and students is supportive of documentary evidence and the evidence is robust, consistent and not contradictory. There may be minor deficiencies in the evidence supplied but these are likely to be inconsequential."

A Requirement is partly met if:

"Evidence derived from the inspection process is either incomplete or lacks detail and, as such, fails to convince the inspection panel that the provider fully demonstrates the Requirement. Information gathered through meetings with staff and students may not fully support the evidence submitted or there may be contradictory information in the evidence provided. There is, however, some evidence of compliance and it is likely that either (a) the appropriate evidence can be supplied in a short time frame, or, (b) any deficiencies identified can be addressed and evidenced in the annual monitoring process."

A Requirement is not met if:

“The provider cannot provide evidence to demonstrate a Requirement or the evidence provided is not convincing. The information gathered at the inspection through meetings with staff and students does not support the evidence provided or the evidence is inconsistent and/or incompatible with other findings. The deficiencies identified are such as to give rise to serious concern and will require an immediate action plan from the provider. The consequences of not meeting a Requirement in terms of the overall sufficiency of a programme will depend upon the compliance of the provider across the range of Requirements and the possible implications for public protection”

5. Inspection reports highlight areas of strength and draw attention to areas requiring improvement and development, including actions that are required to be undertaken by the provider. Where an action is needed for a Requirement to be met, the term ‘must’ is used to describe the obligation on the provider to undertake this action. For these actions the education associates must stipulate a specific timescale by which the action must be completed or when an update on progress must be provided. In their observations on the content of the report, the provider should confirm the anticipated date by which these actions will be completed. Where an action would improve how a Requirement is met, the term ‘should’ is used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The Education Quality Assurance team aims to send an initial draft of the inspection report to the provider within two months of the conclusion of the inspection. The provider of the qualification has the opportunity to provide factual corrections on the draft report. Following the production of the final report the provider is asked to submit observations on, or objections to, the report and the actions listed. Where the inspection panel have recommended that the programme is sufficient for registration, the Council of the GDC have delegated responsibility to the GDC Registrar to consider the recommendations of the panel. Should an inspection panel not be able to recommend ‘sufficiency’ or ‘approval’, the report and observations would be presented to the Council of the GDC for consideration.

7. The final version of the report and the provider’s observations are published on the GDC website.